PATRICK W. FINNERTY
DIRECTOR

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 6, 2008

MEMORANDUM

TO: Ms. E. Kim Snead
Executive Director, Joint Commission on Health Care.

FROM: Patrick W. Finnerty, Director

SUBJECT: Follow-up Questions from Joint Commission on Health Care Meeting, September 4, 2008

Thank you again for the opportunity to present on a variety of Medicaid topics to the Joint Commission on Health Care's Long Term Care and Medicaid Reform Subcommittee on September 4, 2008. At the conclusion of my presentation, Delegate Hamilton asked for a follow-up on four issues: (1) provide an overview of Enhanced Benefit Account programs from other states; (2) provide an ongoing status report on our recently released Request for Proposals (RFP) on Chronic Care Management; (3) provide additional explanation on the inflation factor utilized for nursing facilities; and (4) provide additional information on the Quality Improvement Program for nursing facilities.

Enhanced Benefit Accounts

The Department of Medical Assistance Services (DMAS) is currently working toward a formal proposal on Enhanced Benefit Accounts (or EBA) for consideration by the Governor and General Assembly. This proposal will be submitted by October 30, 2008. To date, only Florida, Idaho, and West Virginia have implemented EBAs in their Medicaid programs. As requested, attached are Power Point slides that provide a brief explanation of those programs.

Chronic Care Management Program: Status Report

DMAS recently posted and received bids on a Request for Proposals (RFP) for a Chronic Care Management Program. The goal of this program is to provide specialized care management to individuals with chronic illness to reduce unnecessary utilization of

Medicaid services. Following the JCHC meeting, DMAS reviewed the bids in this procurement. Due to the substantially higher than expected costs that were submitted by the vendors who responded to the RFP, the difficult state budget situation, and the uncertainty of obtaining federal approval, DMAS is postponing this procurement. However, we are exploring other short term and long term options for managing the care needs of this population through a chronic care management program.

Inflation Factor for Nursing Facilities

DMAS' state regulations specify exactly what inflation factor DMAS must use each year in setting nursing home rates. The regulations are specific enough that there is no room for discretion on the part of the agency. The regulations specify a factor that is published by a commercial forecasting firm, and that is released in late March or early April of the calendar year to which the inflation factor is applied. This means that when the General Assembly is deliberating over possible budget amendments, and requests that DMAS provide information on nursing home inflation, the final inflation factor for the coming year is not yet known, and DMAS must rely on an estimate. This estimate is taken from the same published source that the regulations direct DMAS to use for the final inflation factor - just from an earlier publication. There is always some difference between these earlier inflation estimates and the final one. Usually the difference is small, but this year it was not.

This year, the largest factor that caused the final inflation factor to differ from the earlier estimate was the incorporation of data from the annual wage survey that DMAS conducts each year. This survey collects wage and other cost data from Virginia nursing homes, and accounts for 81 percent of the costs included in the inflation factor. This year, the data reported by the nursing homes themselves showed a cost increase lower than expected and accounted for most of the change from the previous inflation estimate.

Quality Improvement Program for Nursing Facilities

During the 2007 Session, Chapter 474 of the Virginia Acts of the Assembly required DMAS to establish a Nursing Facility Quality Improvement Program and develop a strategic plan for this program and the potential use of Civil Money Penalty (CMP) Funds. CMP funds have been collected from nursing facilities that have been found to be out of compliance with Federal requirements for nursing facility care. Attached is a copy of a January 2007 letter, which identifies the initial organizations that were invited to participate in this endeavor. The advisory group that was formed has met regularly since 2007 to develop the required strategic plan; the initial report on this plan was provided to the General Assembly prior to the 2008 session. At this time, the strategic plan is to develop a best practice model, which focuses on recruitment and

retention of nursing staff. This model will be made available to Virginia nursing facilities on a voluntary basis. Implementation of any model, however, is subject to the availability of CMP funds or funding from another source.

DMAS has continued to work with both the nursing facility industry and the advocates to develop areas of agreement. At this time, the key concerns of the Virginia Health Care Association (VHCA) are the utilization of civil money penalty funds and how the best practices model will be implemented in Virginia. Currently, CMP funds are only used to pay for services required of nursing facilities that are at risk of federal and state termination of their Medicare and Medicaid certification. A meeting was held with several nursing home administrators on September 25, 2008 at the VHCA to discuss their concerns and what they believe would be most helpful to incorporate in a QIP. An additional meeting of the QIP Advisory Committee is scheduled for October 27th to continue these discussions.

If you have any additional questions on any of these topics, please feel free to contact me. As always, we appreciate the opportunity to work with the Joint Commission on Health Care on these and other important health care topics.

/pwf

Enclosures
Cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

Patient Incentives in Other State Medicaid Programs

- Only a few states have implemented EBAs in their Medicaid programs, although several states have expressed an interest in the concept
  - Florida and Idaho have the most experience (to date) with EBAs under Medicaid
  - It may be too soon to judge the effectiveness of these programs; however, an evaluation conducted by Georgetown University points to several challenges faced by the Florida EBA program

Florida's EBA Program

- EBAs are part of a larger Medicaid Reform effort, and were implemented in September 2006
- Under the Florida program, clients can earn up to $125 per year for keeping well child visits or participating in DM programs
- Medicaid-participating managed care organizations track behaviors through both claims and other data collection instruments and send this information to the state Medicaid agency
- The Medicaid agency sends letter to clients advising them of their EBA balance
- Clients redeem rewards at participating pharmacies and get over-the-counter health products not covered by Medicaid

Florida's EBA Program
(continued)

- Georgetown University recently conducted an evaluation of Florida's EBA program. Among their main findings:
  - Early experience shows clients are earning rewards but a significant number have not redeemed the rewards
  - Most of rewards have been earned for visits to the doctor
  - So far, no one has earned rewards for smoking cessation and weight loss efforts
  - Researchers question whether the program is producing behavioral changes as intended

Idaho's EBA Program

- Idaho's patient incentive program is called Preventive Health Assistance (PHA), is also part of a larger Medicaid reform effort
- The program was implemented in January 2007 and has two components:
  - Wellness PHA--SCHIP Children who keep well child appointments and immunizations current earn up to $30/quarter which is used to pay for premiums
  - Behavioral PHA—Children and adults who sign up for weight management programs or tobacco cessation support get up to $200 to pay for these programs
- State officials indicate they are satisfied with progress in these programs and plan to continue them for the foreseeable future

West Virginia's EBA Program

- West Virginia's Comprehensive Medicaid Reform effort is an example of the stick approach to promoting healthy behaviors
- Clients that do not agree to utilize a medical home, comply with scheduled appointments and plans of care, and use the emergency room only in an emergency will receive a basic benefits package that has fewer benefits than were available under Medicaid prior to the reform
  - Recent reports in the media have indicated that the enrollment in the program is low. Less than eight percent of eligible participants have signed the agreement to receive more comprehensive benefits. State officials have indicated that it is too soon to judge the success of their reform program
- Clients that sign agreements will also receive rewards for healthy behaviors which can be used for co-payments and non-covered services (this component has not been implemented yet)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 18, 2007

Ms. Joani F. Latimer
State Long-Term Care Ombudsman
530 East Main Street, Suite 800
Richmond, VA 23219

Dear Ms. Latimer:

Thank you for the opportunity to discuss House Bill 2290 this morning regarding use of the Civil Money Penalty Funds.

The Department of Medical Assistance Services looks forward to the development of a Quality Improvement Process that best serves the elderly and persons with disabilities in our nursing facilities throughout the Commonwealth. As such, we will invite to participate in our efforts representatives from the following organizations, as well as any others who have an interest in this endeavor:

Virginia Department of Health
Virginia Department for the Aging
Office of the Inspector General, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Virginia Department of Social Services
Virginia Association of Home Care and Hospices
Virginia Association of Non-Profit Homes for the Aging
Virgina Health Care Association
Virginia Hospital & Healthcare Association
Virginia Coalition for the Aging
Virginia Association of Professional Nursing Assistants
Alzheimer's Association
AARP of Virginia
Virginia Association of Personal Care Assistants
Virginia Association of Area Agencies on Aging
Virginia Office of Protection and Advocacy
Virginia Center on Aging

Virginia Health Quality Center
TLC4LTC
Virginia Culture Change Coalition
State Long-Term Care Ombudsman
Virginia Pressure Ulcer Resource Team

We look forward to this opportunity to collaborate together. Thank you.

Sincerely,

Patrick W. Finnerty

Cc: The Honorable Vivian E. Watts